BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOHN S. TRUITT, M.D.** Holder of License No. **21749** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-03-0378A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 11, 2004. John S. Truitt, M.D., ("Respondent") appeared before the Board with legal counsel Skip Donau for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 21749 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-0378A after receiving an anonymous complaint regarding Respondent's care and treatment of a 57 year-old female patient ("PL").

4. In 1997 PL was diagnosed with ovarian cancer and underwent a hysterectomy and oophorectomy followed by chemotherapy. In 1999 the cancer recurred in her abdomen and she underwent another course of chemotherapy. In April of 2002 a CT scan of the abdomen and pelvis, a chest x-ray and LS spine films did not demonstrate

evidence of metastasis, but because of a rising CA-125 PL began a course of Carboplatin/Taxotere chemotherapy and her CA-125 decreased to 18. On July 29, 2002 PL was admitted to Casa Grande Hospital with a dense left hemiparesis. A Gadolinium enhanced MRI was consistent with a right temporal, occipital, and peduncular infarct. A carotid ultrasound showed no high grade stenosis. A esophagram showed aspiration and a bone scan showed no evidence of metastasis. A radiation oncologist who evaluated PL recommended no intervention and deferred to the attending neurologist. The attending neurologist and a medical oncologist concluded that PL did not have metastatic disease to the brain.

5. On August 22, 2002 PL was transferred to Desert Valley Care Center. PL made little neurological recovery. Respondent evaluated PL on August 22, 2002 and performed a planning CT scan without contrast that was reviewed by a radiologist who opined that it demonstrated no evidence of hemorrhage or mass effect. Respondent diagnosed brain metastasis and treated PL with whole brain irradiation, specifically, Respondent administered 10Gy (of a prescribed 50 Gy) in five fractions from August 26, 2002 through August 30, 2002. Respondent and PL voluntarily discontinued the radiation treatment in September 2002. PL subsequently entered hospice care and expired soon thereafter.

6. Respondent testified that when he saw PL and reviewed the films he saw a lytic lesion, or what he thought was a lytic lesion on the CT scan. Respondent stated that he thought the bone scan was mildly positive within the occipital region, the exact same location of the lytic lesion. Respondent stated that he thought the MRI was suggestive of a separate focus within the internal capsule on the right-hand side of the brain.

7. Respondent testified that he discussed this with PL and also discussed it at length with the referring physician. Respondent testified that the mutual discussion was

that if he was to institute radiation therapy, and this was indeed a metastatic focus that caused the stroke in the first place, perhaps he could retard or delay or perhaps even prevent further neurological compromise. Respondent testified that for these reasons he offered PL the radiation therapy.

8. Respondent testified that he did offer PL a PET scan, but it was not available in Casa Grande. In order for PL to have the scan she would have had to be transported to and from Phoenix by ambulance and Respondent did not feel that was a reasonable thing to do. Respondent also noted that he did not do a biopsy because it would have required an open craniotomy, which he felt was unreasonable. Respondent testified that after a long discussion with PL it was her desire to, and she was agreeable to, attempt radiation therapy even though she knew that he could be mistaken and that in the long run her long-term survival was likely to be quite short and the potential for any injury would be extremely remote.

9. Respondent testified that he treats on average one or two brain metastatic lesions per month. Respondent was asked to describe the best way to diagnose a metastatic lesion. Respondent testified that usually he would get a contrasted and non-contrasted CT scan, and if they were questionable, he would do an MRI. Respondent stated that the reason he does the CT scan first is because it is more readily accessible. In response to a comment from the Board Respondent agreed that in one to two percent of the cases ovarian cancer will metastasize to the brain. Respondent said that whether ovarian cancer metastasizes to the brain depends on the length of the patient's survival, for instance, the longer the patient survives with frequent failures, the more likely it is to occur.

10. Respondent was asked how a patient with metastatic lesions usually presents. Respondent testified that such a patient presents with nausea, vomiting,

fatigue, instability in gait, and change in mental status. Respondent was asked to explain the reason for these symptoms. Respondent testified that the patients either have CSF involvement where there are malignant cells in the fluid around the brain or they could have increased intracranial pressure. Respondent was asked if he was familiar with the history of how PL presented to the hospital in Casa Grande. Respondent testified that he had the history that PL gave him at the time he evaluated her, specifically that she had been suffering from nausea, vomiting, dizziness and instability of gait for approximately two to three weeks prior to falling down at which time she had a CT scan done.

11. Respondent was asked if he reviewed the hospital records of the referring physician and other hospital records. Respondent stated that he had, but could not recall the exact history they obtained on PL's admission to the hospital. Respondent did recall that they suspected a metastatic lesion of PL's brain at the time of her admission.

12. The Board noted that PL's history was that she had a very sudden onset of hemiparesis – a weakness of the arm and leg. Respondent was asked if the sudden onset of hemiparesis would be more likely that of a stroke than that of metastatic disease. Respondent testified that his impression was that PL had something going on in her head for several weeks, culminating in a stroke and that a stroke would indeed be a rapid onset phenomenon. Respondent was asked what his opinion was when he looked at the CT scan. Respondent testified that the CT scan looked as though PL had an area of low attenuation on the right parietal that was consistent with either a stroke or edema. Respondent stated that PL also had a suggestion of a mass, a lytic lesion in the occipital region.

13. Respondent testified that he did not discuss the results of the CT with a radiologist. Respondent testified that his impression after he reviewed the MRI was that it was conclusive for a bleed in the right parietal, but he also thought there was a

separate focus in the internal capsule on PL's right side. Respondent was asked if a subsequent bone scan confirmed his diagnosis. Respondent testified that the bone scan was mildly positive in the occipital region. Respondent was asked if he discussed the bone scan with a radiologist. Respondent testified that he had and the radiologist was concerned that the increased uptake in the occipital region could have been due to rotation on PL's part. Respondent testified that the radiologist's impression was that the bone scan was negative and agreed with the Board that the radiologist said there were no findings to indicate skeletal metastatic disease and that, with respect to the mild increase in activity, there was probably a related projection that was slightly off.

14. Respondent was asked to describe the results of doing whole brain radiation to a patient with a stroke. Respondent testified that he did not know because this was the first time he treated a patient that was accompanied by a stroke. Respondent testified that if he saw a patient with findings identical to those of PL he would recommend additional studies to try to narrow things down better. Respondent was asked why he did not suggest additional studies in PL's case. Respondent stated that he did suggest a PET scan, but it was not readily available. Respondent was asked that, since he and the radiologist had a difference of opinion on both the CT bone scan and the MRI, if he considered sending the films to a neuroradiologist elsewhere in the State. Respondent stated that he was covering Casa Grande on a one-day-per-week basis and saw PL in the late afternoon. Respondent stated that he had to evaluate her and do whatever he was going to do and the following week when he came back he would meet with the radiologist, but when he came back the next week PL was hospitalized with a bowel obstruction, so he never had the chance to meet with the radiologist.

15. Respondent testified that his thought process was to try to prevent further neurological compromise in PL, specifically if the bleed progressed because of the metastatic focus causing her to have that bleed. Respondent testified that he thought perhaps he could prevent PL from becoming aphasic or completely paralyzed or some other devastating effect of the progression of her disease. Respondent noted that he imagined PL's long-term survival would not have exceeded six to nine months under the best circumstances.

16. Respondent was asked if it was contraindicated to do total brain radiation in someone who has had an intracranial bleed. Respondent stated that he did not know of any studies that have looked at treating people with strokes with radiation therapy. Respondent testified that when you treat other types of cancer you can stop bleeding, for instance in cervical cancer, endometrial cancer, or wherever there is a hemorrhage. Respondent did note that he did not think any radiation oncologist would recommend palliative treatment to the brain for a stroke or bleed or infarction.

17. The standard of care in a case where the patient has just had a stroke and there was no emergency requirement that the patient undergo radiation therapy requires additional testing or a second opinion from another radiologist to confirm a metastatic lesion before proceeding with whole brain radiation.

18. Respondent fell below the standard of care because did not conduct additional testing or consult with another radiologist to confirm a metastatic lesion before he proceeded with whole brain radiation in a patient who had just had a stroke.

19. PL was subject to potential harm because if she had completed the course of brain radiation prescribed by Respondent and survived for more than two years she would have been at increased risk for cognitive, memory and other neurological deficits.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(26[1])(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for inappropriately treating a patient with probable stroke syndrome with whole brain radiation without reasonable evidence of the presence of a metastatic brain tumor.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

---

[1] Formerly A.R.S. § 32-1401(24). Renumbered effective September 18, 2003.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 21ST day of APRIL, 2004.

THE ARIZONA MEDICAL BOARD

By Barry Cassidy
BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 21st day of April, 2004 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 21st day of April, 2004, to:

Skip Donau
Donau & Bolt
3505 North Campbell – Suite 501
Tucson, Arizona 85719-2033

Executed copy of the foregoing mailed by U.S. Mail this 21st day of April, 2004, to:

John S. Truitt, M.D.
Address of Record.

Jean Loughran